MDR Tracking Number: M5-04-3483-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-7-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The Surgical supplies and a transreceiver on 9-17-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 9-23-03 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

HCPCs code E0752 was preauthorized, therefore this is an incorrect denial code. In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 9/15/03 authorizing this exact HCPCs code for these leads. This service was rendered on 9/17/03. The carrier denied these sessions for unnecessary medical treatment based on a peer review. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." According to the Medical Fee Guidelines effective 8-1-03, E0752 is reimburseable at $465.61 per unit. ($372.49 x 125%). The requestor provided HCFA's detailing that 8 units were billed and delivered to the injured worker. Therefore,

reimbursement is recommended in the amount of $3,724.88 in accordance with Rule 134.600 (b)(1)(B).

This Finding and Decision is hereby issued this 22nd day of November 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for date of service 9-17-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 22nd day of November 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:
MDR Tracking Number: M5-04-3483-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

November 15, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurosurgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

This now 36-year-old gentleman has had apparently a Workers' Comp injury on ___. Unfortunately, the medical records received did not discuss the cause of his injury. However, the information discusses the fact that as a result of that he has developed complex regional pain syndrome. For this he has had a trial dorsal column stimulator as well as a right stellate ganglion block. Despite this he continues to have difficulties. He has made progress, but he is still being described as having complex regional pain syndrome I. The last clinical information on this patient is about ten months old and it is dictated by the patient's pain management physician, Dr. C, and describes the surgical placement of an indwelling epidural spinal cord stimulator in the cervical region for his complex regional pain syndrome. Apparently, placement of the stimulator was quite successful, reducing his pain to a 1/10.

Additional records were received which were physician reviews discussing whether ___ has suffered reflex sympathetic dystrophy from a crush injury to his hand in ___.

REQUESTED SERVICE(S)
Surgical supplies and a transreceiver.

DECISION
Approved.

RATIONALE/BASIS FOR DECISION
Complex regional pain syndrome is amazingly difficult to deal with. Dorsal column stimulation is now an accepted form of treatment for this. There are multiple citations in the literature which found it to be efficacious. At least in the middle of December of last year, the patient was also receiving benefit from that spinal cord stimulator and therefore his need for narcotics will be reduced and his level of functionality will improve.

It is very reasonable that this patient be considered for a spinal cord stimulator for reflex sympathetic dystrophy. RSD is not uncommonly associated with peripheral nerve injuries. In fact, it is one of the most common reasons for developing a complex regional pain disorder. Recently a number of studies have shown that spinal cord stimulation is an excellent mode of treatment for somebody with reflex sympathetic dystrophy which historically has been quite problematic in terms of treatment. Therefore, this reviewer echo's any physician sentiment to place a spinal cord stimulator in ___, particularly with a trial first, and if that trial proved to be successful, then implant the system permanent. Therefore, this intervention is both reasonable and necessary.